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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RENEE MICHELE HAAS** **5200 Irvine Blvd, # 320** **Irvine CA, 92620** **Registered Nurse Licenser No. 278747** **Nurse Practitioner Certificate No. 8006** **Nurse Practitioner Furnishing Certificate No. 8006** Respondent.	Case No. 2013-757 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs

2. On or about June 30, 1977, the Board of Registered Nursing issued Registered Nurse Licenser Number 278747 to Renee Michele Haas (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2014, unless renewed.

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3. On or about November 01, 1995, the Board of Registered Nursing issued Nurse Practitioner Certificate Number 8006 to Renee Michele Haas (Respondent). The Nurse Practitioner Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2014, unless renewed.

4. On or about July 30, 1996, the Board of Registered Nursing issued Nurse Practitioner Furnishing Certificate Number 8006 to Renee Michele Haas (Respondent). The Nurse Practitioner Furnishing Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2014, unless renewed.

JURISDICTION

5. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2750 of the Code states:

> "Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof Code, § 2700 et seq.)]. As used in this article, "license" includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

7. Section 2764 of the Code states:

> "The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

STATUTORY PROVISION

8. Section 2761 of the Code states:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> "(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

REGULATIONS

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COSTS

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

CAUSE FOR DISCIPLINE

(Incompetence)

12. Respondent is subject to disciplinary action under section 2761(a)(1) in that she demonstrated incompetence, as defined by California Code of Regulations, title 16, sections 1443 and 1443.5, in her lack of proper treatment of SH, a pregnant woman, who subsequently lost the infant due to couvclaire uterus with a complete placental abruption and resulting complications. The circumstances are as follows:

13. Respondent worked at Vista Way OB-GYN Medical Group in Oceanside, California, a group practice consisting of four OB/GYNs and two NPs. Obstetrical patients generally would see several of the group's professionals during the course of their pregnancy.

14. Patient SH was a 35 year old woman pregnant with her fourth child. She had a history of kidney problems, thyroid problems, bronchitis, elevated blood pressure during pregnancy, low platelets, toxemia, migraines, and she was obese.

15. SH had had 3 previous cesarean sections, 2001, 2003, & 2005. In 2001 it was documented that the cesarean section was for breech and she had hypertension. In 2003, her pregnancy was breech and she had pre-eclampsia.

16. With this pregnancy, SH was seen regularly and medical personnel were monitoring her for the potential for pregnancy induced hypertension (PIH).[1] She was under PIH precautions.

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[1] Over the years, terminology has changed from preeclampsia/eclampsia to pregnancy induced hypertension and then to the current favored term, gestational hypertension. Hypertension is one of the most common medical risk factors among women who give birth to live babies. It effects as many as 7-10% of all pregnant women and is a significant cause of maternal and neonatal morbidity and mortality. Risk factors include but may not be limited to: pre existing hypertension, renal disease, previous history of pre eclampisa or eclampisia, obesity, advanced maternal age, and African-American ethnicity. The majority of perinatal losses are related to placental insufficiency which causes interuterine growth restriction, prematurity associated with preterm delivery, or abruption placenta.

Women with mild gestational hypertension/preeclampsia or worsening chronic hypertension but without criteria for severe disease may benefit from brief hospitalization to evaluate maternal-fetal status and to develop a management plan. Delivery should be strongly considered for all women with hypertensive disorders at term (>37 weeks). Delivery should be

(continued...)

17. Respondent saw SH on several occasions during her previous pregnancy and on two or three occasions during this pregnancy. Weeks before the incident giving rise to this accusation, Respondent sent SH to the hospital because of high blood pressure and protein in her urine. She was not treated for her high blood pressure at that time and she was released. Four days later, she was again sent to the hospital by another physician, and she was again not treated for high blood pressure and released.

18. On February 16, 2009, Respondent was monitored in labor and delivery. She was sent home from labor and delivery with normal PIH labs and blood pressure and she had an appointment in one week. She was advised to call back with headaches, blurry vision or any other concerns so she could be seen sooner.

19. On February 20, 2009, SH called at 11:37am and the notes in the chart reflected "157/98, 155/111, c/o headache, positive fetal movement." She came in that afternoon, at 3:26pm, for a blood pressure check (148/90) and was sent to labor and delivery. Later that day, she was sent home and placed on bed rest all weekend.

20. On February 23, 2009, SH called in at 3:00pm complaining about a bad headache and increased blood pressure. She was told to come in at 11:00am to have her blood pressure, urine, and weight checked. When SH came in that afternoon, she was seen by Respondent, who wrote the following notes:

Date	Gestation	B/P	Weight	Glucose	Protein	Comments
2/23/09	37w 5d	152/90	304	Neg	Neg	Normal reflexes – assume states: no epigastric pain
		170/90[2]				

an option even for women with mild gestational hypertension because disease progression is likely. The reasoning is that the potential risks to the fetus by increasing placental compromise or sudden abruption are greater than those that may occur due to prematurity. Delivery remains the only definitive treatment.

[2] The diagnosis of mild gestational hypertension/preeclampsia:
- Blood pressure 140mm Hg/90mmHg sustained;
- Protienuria – greater than 0.3gms in a 24 hour urine collection;

(continued...)

21. In her statement to the investigator, Respondent reported:

"On Monday when I saw her for the doctor her blood pressure was 150/90. There was no protein in her urine or other signs of PIH. I asked my medical assistant to turn her on her left side and retake the blood pressure. The blood pressure was 170/90. Here is where the breakdown occurred. The MA did not inform me of the blood pressure. Usually the patient remains in the exam room or the chart remains on my station so I would go back into the patient's room. In this case none of that occurred. The MA failed to report the elevation in the BP, the patient left and the chart was sent back to file by the MA. I completely forgot to ask about the blood pressure, but should have been told about the elevation. The day was extremely busy, I had 25 patients that day. It was two days later when SH suffered a placental abruption at home.

"Placental abruptions are a true obstetrical emergency but are completely unpredictable. There are some conditions that make a patient more likely to have an abruption. SH had high blood pressure although it was labile.

"SH had a history of PIH in her first pregnancy and labile hypertension in all. She weighed 305lbs. I sent her to the hospital twice during her previous pregnancy and was also sent home both times then. I say that because I have a history with this same patient, of sending her to the hospital 3 times for elevated blood pressure. It is that I routinely do in this situation if I am aware of the elevation."

22. On February 25, 2009, at 38 weeks pregnant, SH presented to labor and delivery with complaints of having gushing blood, noted approximately an hour prior to arrival to the hospital. The patient at that time stated that she had been having continuous severe lower abdominal pain. Previous to this, she was sleeping comfortably. She was found to have a large amount of clots and active bleeding. She was taken immediately to the operating room where she was diagnosed as having couvclaire uterus with a complete placental abruption. Her baby was resuscitated after 12 minutes of resuscitative efforts, but died within 24 hours.

- Edema – excessive weight gain > 4lbs/wk in the 3rd trimester (Maybe a sign although 39% of hypertensive/eclamptic patients have no edema and moderate edema is normal in 80% of pregnancies.)

The diagnosis of severe gestational hypertension/preeclampsia:

- Blood pressure of >160mm Hg systolic or >100mm Hg diastolic on two occasions at least six hours apart with the patient at bed rest;
- Protienuria of > 5 gms in a 24 hr urine collection or 3+ or greater in two random urine samples collected at least four hours apart;
- Oliguria < 500ml/24 hrs;
- Cerebral or visual disturbances;
- Epigastric or right quadrant pain;
- Impaired liver function;
- Thrombocytopenia;
- Fetal growth restriction.

23. A lawsuit was subsequently filed resulting in a settlement for $100,000.00 on behalf of Respondent which the insurance company reported to the Board.

24. Respondent's care of SH was incompetent in that she failed to exercise that degree of care and experience ordinarily possessed and exercised by a competent registered nurse. A prudent nurse practitioner would have recognized the severity of SH's condition and would have taken steps to ensure that she did not leave the clinic until a plan of care had been established. SH's initial blood pressure was elevated enough to diagnose her with mild gestational hypertension. Then with review of her chart an experienced nurse practitioner would recognize a potential disease process. Although it may not have changed the outcome of the case, Respondent should have sent SH to labor and delivery or consulted with a physician for a plan of care. Respondent's treatment of SH shows a lack of possession or the failure to exercise that degree of learning or the failure to exercise that degree of learning, skill, care, and experience ordinarily possessed and exercised by a competent nurse.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse Licenser Number 278747, issued to Renee Michele Haas

2. Revoking or suspending Nurse Practitioner Certificate Number 8006, issued to Renee Michele Haas;

3. Revoking or suspending Nurse Practitioner Furnishing Certificate Number 8006, issued to Renee Michele Haas;

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4. Ordering Renee Michele Haas to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

5. Taking such other and further action as deemed necessary and proper.

DATED: March 14, 2013

for LOUISE R. BAILEY, M.Ed., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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